Principles for Establishing Medicare Advantage Regions
To Maximize Access to High-Quality Regional Plans

CMS considered a number of key factors in establishing Medicare Advantage regions. We developed these factors through data analysis informed by a market survey, written comments, a public meeting, and an open door forum. The key principles are:

1. Appropriate Size of Eligible Population. An adequate population is required to assure the plan will be viable (above 200,000 eligibles is necessary to be able to form networks and offer favorable rates to enrollees) but not too large a population that would inhibit start-up capacity in the first year. If the size of the region is too large (i.e. greater than about 3 million eligibles), plans may have difficulty enrolling and providing services to beneficiaries, especially in the start-up year.

2. Multiple Potential Plan Entrants. A sufficient number of existing plans, such as commercial Preferred Providers Organizations (PPOs), Federal Employees Health Benefits (FEHB) plans and local Medicare Advantage plans are necessary to assume that potential plan entrants will participate. Several data sources including state licensing data, the presence of commercial PPOs, current operation of Medicare Advantage plans, and current FEHB plans indicate that potential plan entrants are available in the region. Further, the data show whether some companies have a history of serving multiple states.

3. Limited Variation in Health Plan Costs. Adequate payments are necessary to encourage plan participation, and providing adequate payments for quality services in all areas within a region may be more difficult if there is high variation in health care costs within a region. Therefore, to avoid the potential effects of cross subsidization, we generally did not join states that have large differences in average payments or that would substantially add to the variability of payments within the region. CMS established regions by minimizing the differences in average state payments within a region and grouped states with similar average payments and variations in payments. In addition, we will adjust payments to regional plans based on the county of residence of beneficiaries who actually enroll in the plan. We are considering various options that would give MA plans flexibility in determining how these local adjustments will be made. Thus, a plan enrolling a beneficiary from a high-cost county within the region would receive a higher Medicare payment than if that plan enrolled a beneficiary from a low-cost county, while all beneficiaries in the plan would have the same benefit package and premium. This protects regional health plans from losses they might incur if their enrollees come disproportionately from high-cost areas, and it avoids paying regional plans too much if their enrollees come disproportionately from low-cost areas. This additional step, in conjunction with designing the regions in a manner to limit cost variation, means that a possible barrier to plan participation will be substantially minimized.

4. Preserve Medicare Patient Flows. An important goal was to limit disruption to natural Medicare "patient flows" – where patients who live in one state seek care in

another. Patient flow is determined using Medicare expenditures data. Although it is impossible to eliminate all disruptions to patient flows, in areas in which beneficiaries are more likely to seek care in another state, we have generally kept those states together. Regardless, PPOs generally ensure access to a comprehensive group of in-network providers that beneficiaries in a particular state might use, even if across state lines.